REMARKS

A. EXPLANATION OF INVENTION

The examiner appears to be fixed on the incorrect assumption that the present invention is an insurance system or plan and/or that all systems for the pre-payment of fees to a clearinghouse for later payment to a service provider somehow must be an insurance system or plan. This is not a correct assumption. While the system of the present invention can be considered as part of the broad category of "health benefits", not all health benefits are insurance products. To help the examiner, a brief description of the system of the invention follows.

Also for the examiner's information, enclosed with this Response are two items of promotional literature for the invention. These items should assist the examiner in understanding the distinction between the system of the present invention and the insurance products described and defined by the references cited by the examiner.

Additionally, as part of this Response, Applicant is including the Declaration under 37 CFR 1.132 of Mike Musgrove. As can be seen from Mr. Musgrove's declaration, Mr. Musgrove is highly experienced in the health benefits field and he specifically declares that the system of the present invention is not an insurance product.

The present invention is a system for payment of professional services to professional service providers. The basic system was developed to be an alternative to medical insurance as medical insurance payments have been decreasing over the years, thus forcing many doctors to stop taking insurance, to decrease the quantity and/or quality of care provided to patients, or to stop providing medical services altogether, such as in the obstetrics and gynecology fields. The system of the present invention, which the Applicant is promoting under the service mark PRIMEXIS™, has just a few basic steps: the payment of a pre-determined amount by the patient each time period to a central clearinghouse; the ability to use any doctor that is a subscriber; the payment of a reduced fee to the doctor each time the patient contracts with the doctor for services; and the payment by the clearinghouse to the doctor for the service provided to the patient.

Employers can subscribe to the plan to provide professional service benefits to their employees. Individuals can subscribe to the plan without having to pay the

typically exorbitant insurance rates required of individuals. The plan can be offered over the Internet or through credit card agencies, by individual doctors, or through independent agents. Additionally, traditional insurance products can be offered in connection with the plan system.

The system allows for the payment of professional services that is not an insurance product yet allows the consumer to have set payments per time period and set payments to professional service providers. As we are sure the examiner knows, typical insurance involves the payment of a premium by an insured to an insurance company. When the insured suffers a loss, such as having to go to the doctor for a medical issue and having to pay the doctor's bill, the insurance company reimburses the insured. With typical medical insurance, the insured subrogates the insurance payment to the doctor, so the doctor can collect the reimbursement directly from the insurance company. For this ease of payment, and for the peace of mind knowing that he or she will receive payment, the doctor agrees to the insurance companies terms of payment. If the doctor does not contract with the particular insurance company of the insured, the insured has to pay the doctor directly, and then the insured must make a claim to the insurance company for reimbursement directly to the insured. The present PRIMEXIS™ system does not do this.

The present invention provides a system for the payment of professional services, in this case medical services, outside of the current insurance system to cover the ordinary and/or basic professional services at a cost-effective rate and in an efficient manner. Both the patient and the doctor subscribe to the services. The patient pays a certain monthly set fee to a clearinghouse (the term "clearinghouse" is used to define the system administration, as disclosed in the patent application). This set fee allows the patient to obtain a set amount of services per month or year. The doctor agrees to provide this set amount of services to the patient. If the patient obtains services from a subscribing doctor, the clearinghouse pays the doctor a set amount for the services - typically the amount generally charged by the doctor. The clearinghouse (and thus the system) has no obligation to reimburse the patient, and therefore is not an insurance plan. Further, as the doctor has subscribed directly with the clearinghouse to receive payments for medical services rendered, the doctor is not in a subrogation position relative to the patient, but is in a direct payment for service position relative to the clearinghouse, and therefore is not in an insurance relationship with the patient or the clearinghouse.

Further, the present system does not set the doctor's fees, as in a typical insurance plan, but allows the doctors to determine their own rates and levels of service provided based on historical data, thus allowing the doctors to provide the proper level of service at the proper price without the need for insurance. This allows the doctor to charge for his or her services at costs more indcative of what the services should cost without the need for insurance to cover such basic medical services - the doctor can establish appropriate fees for each service and to provide the appropriate level of service without having an insurance company decide what level of service should be provided to the patient.

B. EXPLANATION OF AMENDMENTS TO CLAIMS

Applicant has amended the claims to clarify the system as a combination of components and steps. Applicant has added several new claims to claim the system as a process in a series of steps. These new claims are derived directly from the original claims. No new matter has been added to the amended claims or in the new claims.

Applicant believes these amendments also address the examiner's concerns under both 35 USC 101 and 35 USC 102.

For the examiner's convenience (and ours), following are independent Claims 1 and 18 as amended.

1. A system for the payment of service fees to service providers for services rendered to service receivers, comprising the steps of:

a. having the service providers subscribe with a clearinghouse to provide services to the service receivers;

b. having the service receivers subscribe with the clearinghouse to receive services from the service providers;

c. allowing the service receivers to select a specific service provider who has subscribed to the clearinghouse to act as a primary service provider for the service receiver;

d. having the clearinghouse collect plan fees from the service receivers on a set periodical basis and distribute at least a portion of the plan fees to the selected service provider on a set periodical basis as payment fees; and

e. allowing the service receivers to receive services from the selected service provider.

18. A method for the payment of medical service fees to doctors for medical services rendered to patients, comprising the steps or:

a. having the doctors subscribe with a clearinghouse to provide a predetermined quantity of medical services to the patients;

b. having the patients subscribe with the clearinghouse to receive medical services from the doctors;

c. allowing the patients to select a specific doctor who has subscribed to the clearinghouse to act as a primary care doctor for the patient;

d. having the clearinghouse collect plan fees from the patients on a set periodical basis for a set period of time and distribute at least a portion of the plan fees to the primary care doctor on a set periodical basis for a set period of time as payment fees; and

e. allowing the patients to receive medical services from the primary care doctor,

wherein the primary care doctors set their own fee schedules for the medical services rendered to the patients and are paid by the clearinghouse according to the fee schedule.

C. EXAMINER'S DEFINITIONS OF TERMS

Applicant notes that the examiner has given her definition of terms Applicant uses in the Specification. As discussed and explained in more detail below, the examiner has given definitions contrary to the express wording in the Specification.

1. Clearinghouse.

First, Applicant uses the term "clearinghouse" as the administrator or administration of the system. There are no administrators of a health care plan of any type at the clearinghouse, and the Specification specifically discloses that the present system is not the type of health care plan defined by the examiner, namely an HMO or a PPO. No one at Applicant's "clearinghouse" oversees anything more than the financial aspects of the system (that is, where the money goes) and the tracking of subscriber service providers and service receivers. Applicant's "clearinghouse" is a prepayment service administration entity.

In the medical example, Applicant's "clearinghouse" keeps track of the doctors and patients, collects the prepayments made by the patients and distributes service

payments to the doctors, and various other minor aspects. Applicant's "clearinghouse" is not involved in any way with choosing the doctors or patients (any may subscribe), directing how the doctors provide or the patients receive services, or deciding on the prices the doctors charge for their services. This is significantly different than the existing health care plans, namely HMOs and PPOs.

Applicant only provides a vehicle where service providers and service receivers (such as doctors and patients, respectively) have agreed to provide a certain amount of service for a certain amount of payment. Applicant's "clearinghouse" does not create income from providing services (as do HMOs and PPOs), but creates income from providing access to the services of subscriber service providers. This is a distinction with a difference.

2. Insurance.

Second, Applicant's system is **NOT** an insurance product or an insurance system. This cannot be stressed enough. In fact, several states including Georgia, Alabama and North Carolina already have found Applicant's system ***not*** to be an insurance product. Insurance products allow for the payment of a premium in exchange for a future promise to cover an expense. In the medical example, an insurance product would require a patient to pay a premium in exchange for providing unknown (both in type and quantity) future medical services. In other words, in the medical insurance products field, the patient pays a premium and the insurance company will pay for all medical expenses, whether minor or major, whether generalist doctor or specialist doctor, and whether outpatient or inpatient (subject most likely to deductibles and co-payments). This is a hedge against future (and possibly very large) medical expenses.

Applicant's system is a prepayment system for a defined type and quantity of services. In this regard, it is more like the Schwartz reference (although, as discussed below, there are significant distinctions) and not at all like the Prudential reference or other current known health insurance products. In the medical example given in the Specification, the patient subscribes to the system for a primary care physician only, and is pre-purchasing a specified amount of medical services from this primary care physician. Thus, the present system allows the patient to prepay, at an agreed rate, for a certain quantity of medical services from a primary care physician. For example, for $50 per month, the patient may be entitled to one

wellness examination, two sick visits, and two immunizations - no more and no less. The present system does not provide for unlimited medical services, like an insurance product, and requires the selection of a primary doctor, and not any doctor who is a member of an insurance company's network.

The examiner is referred to the attached Declaration Under 37 CFR 1.132 of Mike Musgrove, a person of significant experience in the field, in which Mr. Musgrove discusses the novelty of the present invention and its distinction fom insurance products.

D. 35 USC 101 REJECTIONS

The examiner's rejection under 35 USC 101 is interpreted to be an issue of the claim language and structure and not an issue of the invention itself. Applicant submits that the amendments to the claims address this issue and that the invention is now claimed in a manner that satisfies the examiner's concerns.

If the examiner's rejection under 35 USC 101 is to the heart of the invention itself, Applicant vehemently disagrees. There are a plethora of issued patents for systems involving humans. Some recently issued patents include US Patent Nos. 6584403 (a fleet operator), 6565437 (a game player), and 6259791 (a service provider).

Further, as originally tendered and now as amended, the claims absolutely do not recite merely an abstract idea. The invention is in use as claimed and the payment of service fees is not merely an abstract idea.

E. 35 USC 102 REJECTIONS

Anticipation under 35 USC 102(b) requires "the disclosure in a prior art reference each and every element of the claimed invention." *Orthokinetics, Inc. v. Safety Travel Chairs, Inc.*, 1 USPQ2d 1081 (Fed. Cir. 1986); *see also verdegall Bros. V. Union Oil Co. of California,* 814 F2d 628, 631, 2 USPQ2d 1051, 1053 (Fed. Cir. 1987) ("a claim is anticipated only if each and every element as set forth in the claim is found, either expressly or inherently described, in a single prior art reference"). The absence of one element from the cited prior reference negates anticipation. *See Atlas Powder Co. v. E.I. du Pont de Nemours & Co.*, 224 USPQ2d 409 (Fed Cir. 1984). Anticipation was intended to apply in the limited situations in which one reference incorporates all the element of a claim in a subsequent invention because

the nonobvious standard was intended to cover broader obvious leaps from a reference to a claim or from combined references to a claim. *See Titanium Metals Corp. v. Brenner*, 227 USPQ 773 (Fed. Cir. 1985).

Prior art for the purposes of anticipation is pertinent art recognized by persons of ordinary skill to be in the ***field of the invention***. *See In re Spada* 15 USPQ2d 1655, 1657 (Fed.Cir.1990). Prior art is pertinent if persons of ordinary skill in the art would have consulted art in that field to develop the invention given the nature ofthe problem. *See In re Paulsen*, 31 USPQ2d 1671 (Fed. Cir. 1994). Specifically, the pertinence of any reference is dependent upon whether it would suggest to persons skilled in the art to do the thing that the applicant has done, and the same is true in considering more than one reference or a reference alleged not to be in the particular art. *See In re Phipps*, 69 USPQ 88 (CCPA 1946).

The federal circuit has applied anticipation narrowly. For example, the Federal Circuit affirmed a district court determination that patents related to a ceramic welding process for repairing industrial furnaces were not invalid for anticipation, notwithstanding that the claims of the patents overlapped with or read on either or both of two prior art patents, because the district court properly determined that the prior art patents were related to flame-spraying and to combustion at the furnace wall. *See Glaverbel Societe Anonyme And Fosbel, Inc. v. Northlake Marketing & Supply, Inc.*, 33 USPQ2d 1496 (Fed Cir. 1995). Even though both inventions had a general relation to combustion, they were not so related that one of ordinary skill in the ceramic welding art would look to the flame-spraying art or the furnace wall combustion art.

The Kennedy reference does not disclose the specific features of the present system as disclosed and claimed. Kennedy is a discussion of managed care coverage fundamentals - specifically HMOs, PPOs and EPOs - and discusses typical insurance plans in which people pay a premium and are assured of a generally unlimited type and quantity of medical services (the term "generally" is used as there likely is a lifetime upper limit to the dollar value of the services, and certain services may not be covered). On the contrary, the present system is not an insurance product, but is a prepayment service, and does not provide the same service level as insurance products such as discussed in Kennedy. Further, the type and quantity of service provided under the present system is limited. The present system albws for the contracting for a certain quantity of services from a specific type of types of

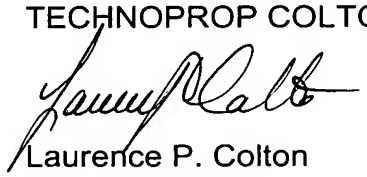
service providers. Any other services required or desired by the service receiver must be paid for by the service receiver (or by a supplemental insurance policy), which is directly opposite the intent and, indeed, the purpose of HMOs. PPOs, and EPOs.

Thus, Kennedy does not disclose each and every element of the present system and is not an anticipatory reference. Therefore, Applicant requests that the Examiner withdraw this ground for rejection.

CONCLUSION

Applicant submits that the Claims are in condition for allowance and requests such actions. If the Examiner has any questions or concerns that can be answered over the telephone, please contact the below-signed attorney of record.

Respectfully submitted,
TECHNOPROP COLTON LLC



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PHYSICIANS

The Company believes that PRIMEXIS™ is more attractive to physicians than traditional insurance solutions because it does not put them at financial risk. Physicians receive predictable streams of revenue, delivered in a timely manner by electronic funds transfer, but without the financial risk of capitated plans.

Benefits of PRIMEXIS

No claim forms to file
No rejection of charges
No withholds
No Utilization reviews or audits
The process is simple and cost-effective

Unlike existing capitated managed care plans, the amount of services and capacity PRIMEXIS™ physicians must reserve per patient is fixed and determinable. The timing of services delivered to specific patients is subject to the per-quarter visit limit. On a practice-wide basis, the per-visit administrative fee provides additional cash flow to cover the additional resources that may be required in periods of peak demand for services. The graduated administrative fee schedule provides additional compensation for extended visits.

AOM's future plans include the development of similar products for other classes of physician practices. Iterations of the product tailored for specialty medicine and practices and for ancillary services are in the early development stage. Certain specialty medicine physicians (i.e. dermatologists and endocrinologists) have asked AOM to consider developing payment methodologies for chronic care that is managed at the specialty level. The Company has also received inquiries about developing and marketing a program for the dental care industry.

The Company's Market

Every person not covered by a government health care plan is eligible to enroll in PRIMEXIS™ (Medicaid and Medicare participants are not eligible for AOM's current program offering). In addition to offering affordable access to those currently uninsured, AOM will market PRIMEXIS™ to those now covered by private insurance, both through individual and group policies, including ERISA health plans.

Insurance agents can market PRIMEXIS™ in conjunction with tailored insurance products that provide a competitive advantage in the private insurance and small employer markets. Agents in the employee benefits industry can carry the Company's program to that majority of the population that currently accesses healthcare through large employer-sponsored health care insurance and managed care programs.

Removing The Barriers Between People And Their Primary Care Physicians

PRIMEXIS

Bringing Accessibility Back To Medical Care.

MISSION

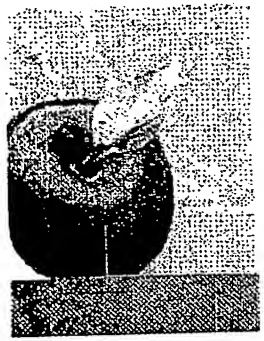
AOM Inc. is Committed to Developing and Implementing Workable Payment Solutions That Benefit all Participants.

ABOUT US

AOM is a company born of a vision for the development of innovative solutions to the revenue management problems currently facing primary care physicians and other physicians. The company was founded in July of 1998 as a primary care practice management company. AOM's mission is to solve the revenue management problems currently facing primary care and other physicians and to make basic medical services available to more people at lower cost. The company intends to grow by marketing PRIMEXIS™ through existing networks of insurance companies and their independent agents, through partnerships with ERISA health benefit plan packagers and administrators, through physician networks and associations, through offices of participating physicians, and through direct sales to employers and to individuals not covered by employer sponsored health plans.

PRODUCT OVERVIEW

PRIMEXIS™ provides a simple solution to the complex problems faced by primary care physicians and healthcare consumers. The PRIMEXIS™ program provides expedited payments to physicians and low-cost access to basic healthcare for consumers--all without the liability, mountains of paperwork, and administrative burdens of conventional healthcare financing. Patients select a primary care physician who agrees to provide a limited amount of primary care services in exchange for fixed monthly payments and variable point of service administrative fees. AOM facilitates patient and physician enrollment and manages the electronic collection and transfer of patient payments, of physician compensation, and of fees and commissions paid to resellers, referrers, networks, and agents.



Primary Care Coverage for $30 a month

8 Office Visits a Year

35% Discount on other Primary Care Office services

PRIMEXIS™ gives you the security of knowing you are covered for services within your primary care physicians office.

PRIMEXIS™ offers a payment plan that covers up to 8 office visits with your primary care physician a year (*maximum of four visits in a three month period*) for a low monthly fee of $30.00. Your physician receives his monthly payments automatically each month and there are no claim hassles for you. The only additional fee will be an administrative fee due to your Physician at the time of service.

0-15 minutes	$10.00
16-30 minutes	$15.00
31+ minutes	$20.00

In addition to 8 office visits, your physician will also offer a 35% discount on other services within that physician's office. These services can include in-house x-rays, labs, EKGs, and medical supplies.

PRIMEXIS™ is not an insurance plan, it is a simple agreement to access your family physician affordably. Your monthly payment may be made in any of the following ways:

Automatic Bank Draft
Check
Money Order

PRIMEXIS' simple agreement will either be renewed automatically at the end of 12 months or you can notify us of your decision in writing not to renew.

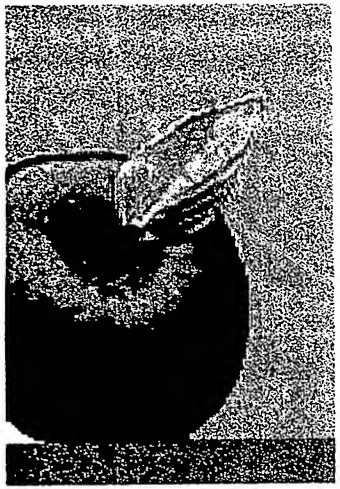
Medicaid and Medicare participants are not eligible for the PRIMEXIS™ program offering.

PRIMEXIS

Bringing Accessibility Back To Medical Care.

PRIMEXIS℠ gives you the security of knowing you are covered for services within your primary care physicians office.

PRIMEXIS℠ offers a payment plan that covers up to 8 office visits with your primary care physician a year (maximum of four visits in a three month period) for a low monthly fee of $30.00. Your physician receives monthly payments automatically there are no claim hassles for you.



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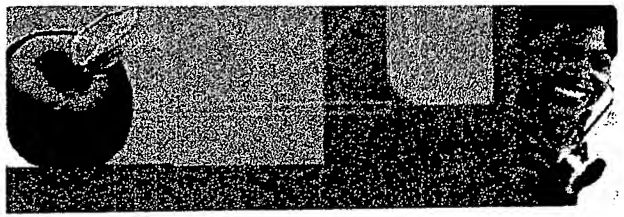
Money Order

PRIMEXIS℠ simple agreement will either be renewed automatically at the end of 12 months or you can notify us of your decision in writing not to renew.



Please call:
(678) 377 - 5455

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www.primexis.com

Write for more information:

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A-603

Atlanta, GA 30338

A Cover Georgia™ product for primary care.

Cover Georgia™

An enrollment fee of $20.00 will be needed to process your application

- **Primary Care Coverage for $30 a month**
- **8 Office Visits a Year**
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Patent
Customer No.: 022870
Docket No.: 20101.002USA

UNITED STATES PATENT AND TRADEMARK OFFICE
PATENT OPERATIONS

Applicant:	Martin, Pamela R.	Art Unit: 3627
Application No.:	10/088795	Examiner: Harle, J.I.
Filing Date:	22 March 2002	
Title:	SYSTEM FOR PAYMENT OF SERVICE FEES	

DECLARATION UNDER 37 CFR 1.132 OF
MIKE MUSGRAVE

Box Response - Fee
Commissioner for Patents
PO Box 1450
Alexandria VA 22313-1450

8 August 2003

Atlanta GA 31156-7685

Sir:

My name is Mike Musgrave. I am 47 years old, and am a healthcare consultant working with hospitals, employers and managed care networks to enhance revenue through contracts and efficiencies related to managed care. I have been in healthcare for 10 years, and have worked for companies such as HCA, Blue Cross Blue Shield, Cigna, and Healthsource. As a consultant I have worked with such organizations and individuals as Newt Gingrich, Doctors Laboratories in Valdosta, and Doctors hospital in Augusta, GA. I currently am an outside independent consultant for AOM, Inc., the provider of the PRIMEXIS™ product that is the subject of this patent application.

I am providing this declaration freely and willingly because I believe that the PRIMEXIS™ product is new and innovative. I understand that this declaration is going

to be provided to the United States Patent and Trademark Office (USPTO) to support the patentability of the patent application for the PRIMEXIS™ product.

In my experience the PRIMEXIS™ product is a new and innovative product that is unlike any product providing access to healthcare that I have seen. This product is a noninsurance product that provides access to healthcare for a set fee, providing known costs for known procedures - a specific service for a specific cost.

Additionally, this product has been so innovative that I presented the product to a health task force set up at the American Enterprise Institute and headed by Newt Gingrich, former US Representative from Georgia and former Speaker of the US House of Representatives. In their view the product was new and innovative enough that Mr. Gingrich used the product as an example of new ideas in healthcare in his most recent book "Saving Lives, Saving Money."

I understand that a brief description of the PRIMEXIS™ product and how it is distinct from insurance products may be of some help to the examiner at the USPTO. While the PRIMEXIS™ product can be considered as part of the broad category of "health benefits", not all health benefits are insurance products. The PRIMEXIS™ product is a system for payment of medical services to doctors. The basic system was developed to be an alternative to medical insurance as medical insurance payments have been decreasing over the years, thus forcing many doctors to stop taking insurance, to decrease the quantity and/or quality of care provided to patients, or to stop providing medical services altogether, such as in the obstetrics and gynecology fields. The PRIMEXIS™ product has just a few basic steps: the payment of a pre-determined amount by the patient each time period to a central clearinghouse; the ability to use any doctor that is a subscriber; the payment of a reduced fee to the doctor each time the patient contracts with the doctor for services; and the payment by the clearinghouse to the doctor for the service provided to the patient.

Employers can subscribe to the plan to provide professional service benefits to their employees. Individuals can subscribe to the plan without having to pay the typically exorbitant insurance rates required of individuals. The plan can be offered over the Internet or through credit card agencies, by individual doctors, or through

independent agents. Additionally, traditional insurance products can be offered in connection with the plan system.

The PRIMEXIS™ product allows for the payment of medical services that is not an insurance product yet allows the patient to have set payments per time period and set payments to doctors. Typical insurance involves the payment of a premium by an insured to an insurance company. When the insured suffers a loss, such as having to go to the doctor for a medical issue and having to pay the doctor's bill, the insurance company reimburses the insured. With typical medical insurance, the insured subrogates the insurance payment to the doctor, so the doctor can collect the reimbursement directly from the insurance company. For this ease of payment, and for the peace of mind knowing that he or she will receive payment, the doctor agrees to the insurance companies terms of payment. If the doctor does not contract with the particular insurance company of the insured, the insured has to pay the doctor directly, and then the insured must make a claim to the insurance company for reimbursement directly to the insured. The PRIMEXIS™ product does not do this.

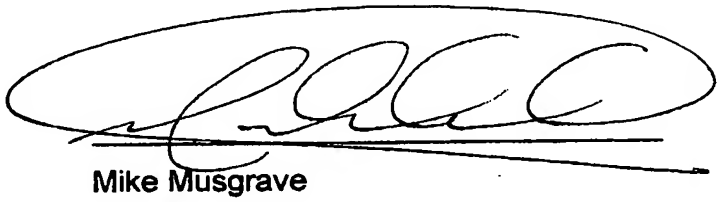
The PRIMEXIS™ product provides a system for the payment of professional services, in this case medical services, outside of the current insurance system to cover the ordinary and/or basic professional services at a cost-effective rate and in an efficient manner. Both the patient and the doctor subscribe to the services. The patient pays a certain monthly set fee to a clearinghouse (the term "clearinghouse" is used to define the system administration). This set fee allows the patient to obtain a set amount of services per month or year. The doctor agrees to provide this set amount of services to the patient. If the patient obtains services from a subscribing doctor, the clearinghouse pays the doctor a set amount for the services - typically the amount generally charged by the doctor. The clearinghouse (and thus the system) has no obligation to reimburse the patient, and therefore is not an insurance plan. Further, as the doctor has subscribed directly with the clearinghouse to receive payments for medical services rendered, the doctor is not in a subrogation position relative to the patient, but is in a direct payment for service position relative to the clearinghouse, and therefore is not in an insurance relationship with the patient or the clearinghouse.

Further, the PRIMEXIS™ product does not set the doctor's fees, as in a typical insurance plan, but allows the doctors to determine their own rates and levels of service provided based on historical data, thus allowing the doctors to provide the proper level of service at the proper price without the need for insurance. This allows the doctor to charge for his or her services at costs more indicative of what the services should cost without the need for insurance to cover such basic medical services - the doctor can establish appropriate fees for each service and to provide the appropriate level of service without having an insurance company decide what level of service should be provided to the patient.

Overall, the PRIMEXIS™ product is a new and exciting way for both patients to have access to affordable healthcare and for doctors to receive acceptable payments for providing the healthcare. Compared to conventional insurance products, such as HMOs and PPOs, this is a breakthrough.

I hereby declare that all statements made herein of my own knowledge are true and that all statements made on information and belief are believed to be true; and further that these statements were made with the knowledge that willful false statements and the like so made are punishable by fine or imprisonment, or both, under Section 1001 of title 18 of the United States Code, and that such willful false statements may jeopardize the validity of the application or any patent issued thereon.

Date: 8-11-03



Mike Musgrave